ABILITY OF MINORS TO CONSENT TO HEALTH CARE
SUMMARY OF LEGAL REQUIREMENTS

Minors are persons less than 18 years of age. The ability of a minor to consent to care may depend upon the type of treatment being sought. For some types of treatment, the statutory law specifically authorizes that minors may provide their own consent. These areas are:

- **Alcohol/Drug Abuse Treatment:** Minors 13 years of age or older can consent to outpatient "counseling, care treatment or rehabilitation" for alcohol/drug abuse from chemical dependency programs certified by DSHS. (RCW 70.96A.095 originally required age of 14 or older; Becca Bill decreased age requirement to 13 years.) Inpatient treatment requires the consent of the parent or legal guardian for all minors unless the child meets the definition of child in need of services in RCW13.32A.030(4)(c).

- **Mental Health Treatment:** Minors 13 years of age or older can consent to outpatient mental health treatment without parental consent [RCW 71.34.030(1)]. To receive inpatient treatment minor 13 or older can voluntarily commit self without parental consent when proper notice is provided to the parents by the facility [RCW 71.34.030(2)].

Statutory law as well as case law expands the ability of minors to provide consent for abortion, birth control and reproductive functions:

- **Abortion, birth control, pregnancy care:** No age requirement for consent to medical care if minor female is capable of giving informed consent. [Reproductive Privacy Act, RCW 9.02 and State v. Koome, 84 Wn.2d901 (1975): right to privacy in matters involving termination of pregnancy and control of one's reproductive functions]

- **Sexually Transmitted Disease/HIV testing:** SKCDPH policy is to provide STD/HIV diagnosis and treatment **regardless of age** due to the Health Department's legally mandated responsibility to prevent the spread of communicable diseases (RCW 70.05.070), the Reproductive Privacy Act (RCW 9.02), and WAC 388-86 on Medical/Care-Emergency Services. Although one state law (RCW 70.24.110) indicates that minors 14 years of age and older can consent to diagnosis or treatment of a sexually transmitted disease, other laws and the Health Department's legal mandate take precedence in this matter.

Treatment without parental consent regardless of age may also be given in the following situations:

- **Minor is married to a person 18 years or older** (RCW26.28.020)

- **Emancipation by court order**

- **Emergency services** (when impractical to get parental consent first)

- **Parent (minor) may consent for treatment of his/her own child**

Mature Minor Rule: In addition to the above referenced statutes and case law which govern a minor's ability to consent based upon the type of care sought, there is a broader legal concept, the Mature Minor Rule, which gives health care providers the ability to make judgments to treat certain youth as adults based upon an assessment and documentation of the young person's situation. The health care provider may consider the minor's age, maturity, intelligence, training, experience, economic independence, and freedom from parental control in determining mature minor status. Generally, age of 15 or older has been considered one of the elements, but this is not as tight a guideline as it used to be. [Smith v. Seibly, 72 Wn.2d 16, (1967)]

Public Health – Seattle & King County
INFORMED CONSENT FOR CERVICAL CRYOTHERAPY

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment;
2. Anticipated results of the proposed treatment;
3. Alternative forms of treatment, including non-treatment; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment.

☐ **Cervical Cryotherapy Procedure**

I understand that I have precancerous cells on the surface of my cervix. These can be treated in the office with cryotherapy. Cryotherapy is a procedure in which a slender instrument is placed into a woman's vagina and held against her cervix. The end of the instrument is then chilled to freezing temperatures to destroy those abnormal cells. The freezing continues for about three minutes, then here is about a two minute interruption and the treatment is continued for another three minutes. During the freezing, I may experience some uterine cramping. These cramps will lessen when the treatment is over. The discomfort may be treated with any medication I usually take for menstrual cramps.

☐ **Possible Complications**

Rarely are there complications from cryotherapy. These include infection, bleeding, miscarriage (if I am pregnant), and possible scarring of my cervix in the future. If I experience any abnormal bleeding, abdominal pain, fevers and chills in the coming weeks, I will return for evaluation or go to an emergency room. After I go home I understand that I will have a watery vaginal discharge or 3-4 weeks. This is the time when my cervix is healing. It is vital that I do not put anything into my vagina during the healing time. This means I should not have sexual intercourse or use tampons for the next month.

☐ **Follow Up**

In order to make certain that my problem has been successfully treated and does not come back, I will need to return to have pap cervical cytology tests every six months for the next two years. About 15% of women cannot be treated by cryotherapy alone and will need another form of treatment like excision (cutting) to prevent invasive cancer of the cervix and this might have to be done by a hospital

☐ I understand the above risks and request cryotherapy of my cervix by PHSKC.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

_____	_____
Date	Signature of Patient / Other Legally Responsible Person if Applicable
_____	_____
Witness	Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health – Seattle & King County
INFORMED CONSENT FOR COLPOSCOPY BIOPSY

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment;
2. Anticipated results of the proposed treatment;
3. Alternative forms of treatment, including non-treatment; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment.

❑ **Colposcopy and Biopsy Procedure**
I understand that this procedure will involve looking with a microscope at my cervix for abnormal precancerous (dysplastic) cells using dilute acetic acid (vinegar) if abnormal cells are seen then a small sampling of tissue (biopsy) will be taken from my cervix with an instrument called a forcep. A chemical called silver nitrate would then be used to make any bleeding stop. There may be some cramping and discomfort during the procedure. A numbing medicine may also be used like lidocaine or benzocaine on my cervix before the biopsy. Rarely, an endocervical curettage (ECC) would be performed and this involves a spoon like instrument placed into the opening of the cervix to scrape cells from inside where we cannot see them. Many times a biopsy many not be needed if there is no evidence of precancer seen by colposcopy.

❑ **Alternatives to the Procedure (if any) have been discussed with me.**

❑ **Benefits of the Procedure:**
- ❑ Help to make a diagnosis of my abnormal pap test
- ❑ May detect cancer of the cervix or pre-cancerous changes
- ❑ Help to plan treatment, if needed

❑ **Risks of the Procedure:**
- ❑ Cramping pain during procedure and 2-3 days after procedure
- ❑ Bleeding, (may occur for several days after procedure)
- ❑ Infection in the cervix or tissue around cervix
- ❑ Allergic reaction to medications ❑ I am not allergic to lidocaine ❑ I am not allergic to benzocaine
- ❑ Can faint from procedure
- ❑ Disruption of unknown pregnancy
- ❑ Missed abnormal tissue (10% risk) & need for further evaluation & possible surgical procedure
- ❑ If no biopsy is done it is important to get another pap in 6-12 months because sometimes abnormal cells can be missed or are too small to see.

❑ **Importance of the follow-up visit to discuss results and possible treatment if needed has been told to me and if I had a biopsy I will make a follow-up visit in 2 weeks to get the results.**

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

_____ _____
Date Signature of Patient / Other Legally Responsible Person if Applicable

_____ _____
Witness Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health – Seattle & King County
INFORMED CONSENT FOR ENDOMETRIAL BIOPSY

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment;
2. Anticipated results of the proposed treatment;
3. Alternative forms of treatment, including non-treatment; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment.

❑ **Endometrial Biopsy Procedure**
I understand that this procedure will take a small sampling of tissue from the lining of the uterus and have been told the purpose of the procedure. I understand that a thin plastic catheter will be inserted into the uterus and a sample of tissue from the uterine lining will be obtained under suction. There may be some cramping and discomfort during the procedure. Occasionally the cervix may need to be dilated to pass the catheter into the uterus which may cause cramping. A numbing medicine may be used like lidocaine or benzocaine on the cervix.

❑ **Alternatives to the Procedure (if any) have been discussed with me.**

❑ **Importance of follow-up to discuss results, treatment, possible referral & repeat biopsy if needed.**

❑ **Benefits of the Procedure:**
- ❑ Help to make a diagnosis of my condition
- ❑ May detect cancer of the uterus or pre-cancerous changes
- ❑ Help to plan future therapy

❑ **Risks of the Procedure:**
- ❑ Cramping pain during procedure and 1-2 days after procedure
- ❑ Bleeding, (may occur for several days after procedure)
- ❑ Infection in the uterus or tissue around uterus
- ❑ Perforation (hole in uterine wall) of uterus (very rare with plastic sampler device)
- ❑ Allergic reaction to medications ρ betadine ρ lidocaine ρ benzocaine
- ❑ Can faint from procedure
- ❑ Disruption of unknown pregnancy
- ❑ Missed abnormal tissue (2-6% risk) & need for further evaluation & possible surgical procedure
- ❑ Rare unusual reaction following any surgical procedure

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

Date _____ Signature of Patient / Other Legally Responsible Person if Applicable _____

Witness _____ Interpreter _____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health Seattle & King County
Family Planning Program

INFORMED CONSENT FOR FAMILY PLANNING CARE

Name (Please Print) _____

Several birth control methods have been explained to me. These may include abstinence, natural family planning, male and female condoms, diaphragm, implants, injections, IUD, sterilization, and birth control pill, patch, or ring. I am aware of the use, effectiveness, and known side effects and complications of each method discussed with me. I understand the information I have been given about each method and have had a chance to ask questions. I also understand that no type of birth control is 100% certain to prevent pregnancy.

I have given the Family Planning Clinic a correct medical history about my health or my family's health. I understand that I will be offered a physical exam before a birth control method is given to me. This exam may include: testicular exam, pelvic exam, breast exam, pap test, blood test, urine test, sexually transmitted disease tests, blood pressure check, height, weight, a test for pregnancy, and other tests the Family Planning provider may decide are needed based on my gender and medical history.

I understand that after the exam I will be given a birth control method based on my needs and the medical findings of the exam. I understand that I should report to this clinic any health problems which may be related to my birth control method. I have been told to call 911 or seek urgent care at a local facility if severe problems occur when this clinic is not open.

I have read this form and understand the information in it.

_____ _____
Date Signature of Patient / Other Legally Responsible Person if Applicable

_____ _____
Witness Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Informed Consent for
A HORMONAL CONTRACEPTIVE Method

EFFECTIVENESS

I am aware that the birth control hormones are not 100% effective, and they are most effective if taken correctly. During the first 7 days of starting, I have been advised that I must use a back-up method, such as condoms or no sex.

BENEFITS

I have been told that the birth control hormones may have some of the following benefits:

- -decreased menstrual cramps and bleeding
- -improvement in acne
- -less risk of certain types of ovarian cysts
- -protection against ovarian and endometrial cancer

SIDE EFFECTS

I have been told that the birth control hormones may sometimes give some women one or more of the following problems which usually get better with time:

- -nausea if estrogen used
- -spotting or bleeding between periods
- -mood or changes in sex drive
- -breast changes or tenderness
- -headaches
- -Rarely there can be hair loss
- -Rarely if estrogen used there can be darkening of the skin of the face

RISK

The birth control hormone estrogen may be associated with blood clots of the legs or lungs, strokes, heart attacks, high blood pressure, gallbladder disease, and liver changes. These problems may rarely result in death. These risks may be increased if a woman is age 35 or older, is a smoker, has high cholesterol, or has a family history of blood clots or heart disease. It is unknown but possible that using the patch can increase this risk of blood clots. I have been told that in order to lessen the chances of serious problems, it is my responsibility to go to a hospital emergency room if I start to have any of the following symptoms:

- -severe abdominal “belly” pain
- -severe chest pain or shortness of breath
- -severe headaches
- -eye problems such as blurred vision, or loss of vision
- -severe leg pain and/or swelling

If I use the medroxprogesterone shot (“Depo”) I have been told my ovaries will not make much estrogen and this can lead to loss of bone density which can increase my risk of bone fracture later in life especially if I use it for more than 2 years

ALTERNATIVES

I have been offered information on all methods of contraception, and I have been told that birth control hormones do not protect against sexually transmitted diseases and only proper condom use can reduce the risk of infection.

QUESTIONS

I have had the opportunity to ask questions. I may request a copy of this form. I understand I will be given the instructions for the proper use of each specific birth control method I choose along with the package insert from the company. I am voluntarily choosing to receive hormonal contraceptives and indicate this by my signature below.

_____

_____

Date

Signature of Patient / Other Legally Responsible Person if Applicable

_____

Witness

_____

Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Salud Pública de Seattle y el Condado de King
Programa de Planificación Familiar

CONSENTIMIENTO INFORMADO PARA ATENCIÓN DE PLANIFICACIÓN FAMILIAR

Nombre (en letra de molde por favor) _____

Me explicaron varios métodos de control de la natalidad. Estos podrían haber incluido la abstinencia, planificación familiar natural, condones masculinos y femeninos, diafragmas, implantes, inyecciones, DIU (dispositivos intrauterinos), esterilización, y la píldora, parches o anillos para el control de la natalidad. Estoy consciente del uso, la efectividad y los efectos colaterales y complicaciones conocidos de cada uno de los métodos que se debatieron conmigo. Entiendo la información que se me ha proporcionado acerca de cada método y he tenido la oportunidad de hacer preguntas. Asimismo, entiendo que ningún tipo de control de la natalidad es 100% seguro para evitar el embarazo.

He proporcionado a la Clínica de Planificación Familiar un historial médico correcto acerca de mi salud o la de mi familia. Entiendo que se me ofrecerá un examen médico antes de darme un método para el control de la natalidad. Este examen podría incluir: un examen testicular, examen pélvico, examen mamario, examen de Papanicolau, análisis de sangre, análisis de orina, análisis de enfermedades transmitidas sexualmente, chequeo de presión sanguínea, estatura, peso, una prueba de embarazo y otras pruebas que el proveedor de planificación familiar podría decidir que son necesarias, sobre la base de mi género e historial médico.

Entiendo que, luego del examen, se me proporcionará un método para el control de la natalidad basado en mis requerimientos y las conclusiones médicas del examen. Entiendo que debería informar a esta clínica sobre cualquier problema de salud que pueda estar relacionado con mi método de control de la natalidad. Se me ha informado que debo llamar al 911 o buscar atención urgente en un establecimiento local, en caso de surgir problemas graves cuando esta clínica no esté abierta.

He leído este formulario y entiendo la información contenida en el mismo.

_____ Fecha

_____ Firma del paciente / otra persona legalmente responsable según corresponda

_____ Testigo

_____ Intérprete

Salud Pública
Seattle y el condado de King
GENTE SALUDABLE. COMUNIDADES SALUDABLES.

Place Patient Information Sticker Here
OR Name & DOB

Consentimiento informado para
un método ANTICONCEPTIVO HORMONAL

EFECTIVIDAD

Estoy consciente de que las hormonas anticonceptivas no son 100% efectivas, y que son más efectivas cuando se toman correctamente. Se me ha informado que debo usar un método de respaldo, tales como condones o debo abstenerme de tener relaciones sexuales, durante los primeros 7 días desde su inicio.

BENEFICIOS

Se me ha informado que las hormonas anticonceptivas pueden tener algunos de los siguientes beneficios:

-disminución de los calambres y sangrado menstruales -menor riesgo de algunos tipos de quistes en los ovarios
-mejora del acné -protección contra el cáncer de ovarios y endometrial

EFECTOS COLATERALES

Se me ha informado que en algunas ocasiones las hormonas para el control de la natalidad pueden ocasionar uno o más de los siguientes problemas en las mujeres, los que normalmente mejorarán con el tiempo:

- nausea si se usan estrógenos
- manchas o sangrado entre los períodos
- cambios de humor o en el libido
- cambios o sensibilidad en los senos
- dolores de cabeza
- En raras ocasiones puede haber pérdida de cabello
- En raras ocasiones puede ocurrir el oscurecimiento de la piel de la cara, cuando se usan estrógenos

RIESGOS

La hormona que se usa como anticonceptivo, llamada estrógeno, puede estar asociada con coágulos de sangre en las piernas o los pulmones, accidentes cerebrovasculares, ataques cardiacos, presión sanguínea alta, enfermedad de la vesícula biliar y alteraciones del hígado. Estos problemas raramente resultan ser fatales. Estos riesgos pueden aumentar si una mujer tiene 35 años de edad o más, fuma, tiene niveles altos de colesterol o un historial médico familiar de coágulos sanguíneos o enfermedades cardiacas. Se desconoce, pero es posible que el uso del parche pueda incrementar el riesgo de coágulos sanguíneos. Se me ha informado que, para disminuir las posibilidades de problemas graves, es mi responsabilidad acudir a la sala de emergencias de un hospital si empiezo a tener cualesquiera de los siguientes síntomas:

-dolores abdominales severos
-dolores severos en el pecho o falta de aire
-dolores severos de cabeza
-problemas oculares, tales como visión borrosa o pérdida de la visita
-dolores severos y/o hinchazón en las piernas

Se me ha informado que, si uso la inyección de medroxiprogesterona (“Depo”) mis ovarios no producirán mucho estrógeno, y que esto puede conducir a la pérdida de densidad ósea, lo cual puede incrementar el riesgo de fracturas de los huesos más adelante en la vida, especialmente si la uso por más de 2 años.

ALTERNATIVAS

Se me ha ofrecido información sobre todos los métodos de contracepción y se me ha informado que las hormonas anticonceptivas no protegen contra las enfermedades transmitidas sexualmente y que solamente el uso apropiado de condones puede reducir el riesgo de infección.

PREGUNTAS

He tenido la oportunidad de hacer preguntas. Puedo solicitar una copia de este formulario. Entiendo que se me darán las instrucciones para el uso adecuado de cada método específico de control de la natalidad que yo elija, junto con las instrucciones de empleo de la empresa. Elijo de manera voluntaria recibir anticonceptivos hormonales y lo indico así al firmar más abajo.

_____ _____

Fecha Firma del paciente / otra persona legalmente responsable, según corresponda

_____ _____

Testigo Intérprete

Salud Pública
Seattle y el condado de King
GENTE SALUDABLE. COMUNIDADES SALUDABLES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health – Seattle & King County
INFORMED CONSENT FOR INTRAUTERINE DEVICE INSERTION

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment is to place an IUD for contraception;
2. Anticipated results of the proposed treatment is to have an IUD;
3. Alternative forms of treatment, including non-treatment methods like pills or shots; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment are discussed below.

IUD Insertion Procedure

I understand that this procedure will insert a plastic device with either copper or progestin into my uterus for birth control. I understand that a metal instrument will be inserted into the uterus to measure the uterus. Then the IUD will be placed into my uterus using a narrow tube. There may be some cramping and discomfort during the procedure. Occasionally the cervix may need to be opened, which may cause more cramping. A numbing medicine may be given by injection like lidocaine or putting benzocaine on the cervix. The IUD strings are then cut to 1-2 inches in length. I am then responsible for checking the IUD is in place by putting my finger in my vagina to feel the IUD strings are there and unchanged once a week for the first few months and then once a month for as long as I use the IUD.

Alternatives to the IUD as a method of birth control have been discussed with me.

❑ **Risks of the Procedure:**

- ❑ No birth control method is 100% and 2 out of 100 women can get pregnant using the IUD. Usually this is because it came out and the woman did not know it.
- ❑ Cramping pain during the procedure and up to 1 week after the procedure.
- ❑ Bleeding for several days after procedure and we recommend no sex for 7 days.
- ❑ Rare (1 in 100) a mild infection in the uterus can happen. It is important to come to the clinic if you have a fever or a lot of pain.
- ❑ Perforation (hole in uterine wall) of uterus is very rare but can happen in 1 in 1000 women and it may need surgery to fix.
- ❑ Allergic reaction to medications for the procedure. I am not allergic to: ❑ betadine ❑ lidocaine ❑ benzocaine
- ❑ You can faint from the procedure. It helps to eat before the procedure visit.
- ❑ Disruption of unknown pregnancy, and I do not think I am pregnant today: ❑ Agree ❑ Unsure
- ❑ If the IUD fails and you get pregnant this could result in an ectopic (pregnancy in the tube) or a miscarriage of a pregnancy. It is very important if you think you are pregnant to see a clinic as soon as possible
- ❑ If you have never been pregnant or had a baby before you should consider carefully if you want an IUD. Women who have never been pregnant can have more pain with the IUD insertion procedure and women using the IUD for more than 3 years may have less ability to get pregnant later if they had never had a pregnancy before.

❑ **Type of IUD**

- ❑ I have read the manufacturer's brochure and have chosen the following IUD to be inserted:
- ❑ T380A Copper Paraguard for 10 years ❑ Mirena (Levonorgestrel or hormone IUD) for 5 years
- ❑ It is important to have an exam in 6 weeks to make sure the IUD is in the right place. I should also continue to get an exam every year.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

Date	Signature of Patient / Other Legally Responsible Person if Applicable
Witness	Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health – Seattle & King County
INFORMED CONSENT FOR CONTRACEPTIVE IMPLANT SYSTEM

I hereby authorize the medical staff of Public Health – Seattle & King county to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment is to place an implant system for contraception;
2. Anticipated results of the proposed treatment is to have an implant system;
3. Alternative forms of treatment, including non-treatment methods like pills or shots; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment are discussed below.

❑ **Implant Insertion or Removal Procedure**

I understand that this procedure will insert a plastic device with progestin into the skin of my upper arm for birth control. I understand that a needle will be used to put in numbing medicine into my skin and then a sharp instrument will be inserted into the skin of my arm to place the implants under my skin. The skin will then be closed with a type of tape. f this is a removal procedure I understand that it could take up to 30 minutes to remove the implant system using instruments to pull out the implants and to remove scar tissue around the implants.

❑ **Possible Risks of the procedure and Implant System:**

- ❑ No birth control method is 100% and 1 out of 500 women can get pregnant using an implant system.
- ❑ Irregular bleeding is very common with implant use. Some women may not have bleeding with implant use.
- ❑ Some women can get headaches, mood changes, or hair loss with implant use.
- ❑ Bruising or swelling of the skin from the procedure is common and can last for 2 to 3 weeks.
- ❑ Sometimes the procedure can cause a permanent scar or change in color of the skin above the implants.
- ❑ Rarely (2 in 100), a mild infection in the skin can happen. It is important to come to the clinic if you have a fever or a lot of pain. Very rarely the implant system can come out of the skin if the infection is bad.
- ❑ Very rarely an injury can happen to your arm nerves, blood vessels, or muscles from the procedure.
- ❑ Allergic reaction to medication for the procedure. I am not allergic to: ❑ betadine ❑ lidocaine ❑ tape.
- ❑ I do not think I am pregnant today: ❑ Agree ❑ Unsure
- ❑ The implant system will not protect you from pregnancy until it has been in place for 7 days.
- ❑ If the implant system fails and you get pregnant this could result in an ectopic (pregnancy in the tube). It is very important if you think you are pregnant to see a clinic as soon as possible.
- ❑ When you have the implant system removed you can get pregnant within 1 to 2 weeks.

❑ I have read the manufacturer's brochure and I have chosen to have the 3 year Implanon rod placed.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All of my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

_____ _____

Date Signature of Patient/Other Legally Responsible Person if Applicable

_____ _____

Witness Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here,
OR Name & DOB

Last updated 04/14/05

Patient Consent

I have read this brochure in its entirety and discussed its contents with my clinician. My clinician has answered all my questions and has advised me of the risks and benefits associated with the use of ParaGard® T 380A, with other forms of contraception, and with no contraception at all.

I have considered all these factors and voluntarily choose to have ParaGard® T 380A inserted by

_____ on date _____

Clinician

Patient Signature _____

The patient has signed this brochure in my presence after I counseled her and answered all her questions.

_____ _____

Clinician Date

This ParaGard® T 380A is scheduled for removal on _____

Manufactured by FEI Products LLC

ECR #1360
1016800

Mirena®

(levonorgestrel-releasing intrauterine system)

(sistema intrauterino liberador de levonorgestrel)

CONSENT FORM
FORMULARIO DE CONSENTIMIENTO

I have read the patient information booklet and have had my questions about MIRENA® answered. I choose to have MIRENA® inserted by

He leído el folleto de información para pacientes y he recibido respuesta a todas mis preguntas acerca del dispositivo MIRENA®. *He decidido que el dispositivo* MIRENA® *sea colocado por*

Health care Provider's Name
Nombre del médico

Patient's Signature
Firma de la paciente

Date/*Fecha*

The patient has signed this consent form in my presence after I counseled her and answered her questions.
La paciente ha firmado este formulario de consentimiento en mi presencia después de haberla asesorado y respondido a sus preguntas.

Health care Provider's Signature
Firma del médico

Date/*Fecha*

The system is scheduled for removal on _____
El dispositivo debe ser retirado por el médico el

Date/*Fecha*

Manufactured for:
Fabricado para:

BERLEX®

Public Health Seattle and King County Family Planning Program

SPECIFIC BIRTH CONTROL METHOD INFORMED CONSENT FORM

The identified birth control method you have chosen could cause the following risks for you:

- ❑ **IUD (Intrauterine Device)**
  - ❑ History of ectopic pregnancy. If you get pregnant using the IUD, the pregnancy is likely to be ectopic.
  - ❑ LNG IUS use after 5 years, understands could be less effective and it must be replaced by 7 years.
  - ❑ T380A IUD use after 10 years, understands could be less effective and it must be replaced by 12 years.
  - ❑ Other: _____
- ❑ **Estrogen Containing Contraception**
  The following risk factors combined with taking estrogen containing methods could lead to blood clots, heart attacks, strokes and possible death. You should strongly consider using no estrogen or only 20 mcg or less of estrogen:
  - ❑ Age under 35 and smoking more than 1 pack of cigarettes every day, age 35 to 45 years old and a smoker, strongly advised to quit or smoke less than 15 cigarettes a day, and if age greater than 45 no estrogen can be prescribed. If non-smoker, up to age 50 is okay but after 50 caution is strongly advised as breast cancer and heart disease risk increase.
  - ❑ Hypertension (if uncontrolled then no estrogen can be prescribed).
  - ❑ High LDL Cholesterol > 180, or High Triglycerides > 500, or low protective HDL cholesterol < 40.
  - ❑ Diabetes requiring insulin with or possible micro-vascular diseases like eye/retinal or kidney/renal disease.
  - ❑ Age 35 and first degree relative with history of heart attack or stroke, <55 if male or <65 if female relative.
  - ❑ First degree relative with history of blood clots can increase your own risk.
  - ❑ Other:_____
- ❑ **DMPA; Medroxyprogesterone; Depo-Provera**
  - ❑ Severe depression on medication, DMPA could make worse.
  - ❑ HDL <40 and possible low estrogen effect so HDL may stay low and no protection from heart attacks.
  - ❑ Planning to use for more than 2 years can cause low estrogen and a loss of bone density and this could increase your risk for bone fractures when you are older. If your age is under 18 or older than 45 then using DMPA for more than 2 years should only be if you cannot use any other method because during the teenage years you should be growing bone and after menopause your risk of bone fracture increases.
  - ❑ Age ≥ 33 years and plans for future pregnancies, DMPA can delay the return to fertility for 1-½ years.
  - ❑ Other:_____
- ❑ **Norplant**, age ≥ 33 years and < 100 kg at time of insertion can use up to 7 years if accepts 1-2% failure rate.
- ❑ **Your urine pregnancy test is positive**, this could be because of your recent pregnancy or a new early pregnancy and you need to return for another test in 2 weeks.
- ❑ **Other**:_____
- ❑ **Continued refusal of Breast and/or Pelvic Exam**
  I understand that by not having a breast or pelvic exam I could have a cancer that will not be found early. Cancers found early are easier to treat and possibly cure. I also know that the pelvic exam can find infections that could lead to infertility if not treated. I do not want these exam services at this time and I ask that I still receive contraceptive supplies including hormonal medications, which could worsen a cancer.

The above information has been explained. I understand that I may be placing myself at an increased risk for health problems from my birth control method. I have been informed of alternative methods but I still request this method.

_____	_____
Witness Date	Patient; Interpreter; Other Legally Responsible Person

Public Health
Seattle & King County
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Place Patient Information Sticker Here
OR Name & DOB

Last updated: 04.12.05

Public Health Seattle and King County
Family Planning Program

Vasectomy Information and Consent Form

I hereby authorize the medical staff of the Public Health – Seattle & King County to provide the treatment listed below. I have been advised of:

- ❑ The nature and character of the proposed treatment;
- ❑ The anticipated results of the proposed treatment;
- ❑ The alternative forms of treatment, including non-treatment; and
- ❑ The recognized possible risks, complications, and anticipated benefits involved in the proposed treatment, and in the alternative forms of treatment including non-treatment.

Vasectomy:

It is important that you have had a preliminary visit with the physician. Our goal is for you to understand the procedure in its entirety, and to have all of your questions answered.

What happens during the surgery:
The vas deferens (vas) carries the sperm from the testes to the urethra (the tube which carries the urine from the bladder to the end of the penis). A vasectomy is the cutting and closing of this vas. The vas is cut and cauterized (burned) in the upper part of the scrotum. In this area it is just under the skin and very accessible. The procedure itself takes approximately sixty minutes and is done by injecting a local anesthetic (such as the dentist uses to fix a tooth) in the skin. A small incision or puncture is made on each side of the scrotum or just a single midline incision. The vas is identified, cut and cauterized. Usually the only discomfort is at the time of injection of the anesthetic.

The following issues should be considered:

1. It is important to refrain from aspirin or other nonsteroidal anti-inflammatory medications like ibuprofen or Naprosyn for five days preceding the procedure.
2. Please inform us if you have ever had a bleeding problem.
3. Please have a driver available.
4. Your “dressing” following the procedure is a supporter (jockstrap) and should be brought to the clinic on the day of your procedure. It also serves as a pressure dressing for a period of time following the vasectomy, usually 24-48 hours will suffice, or longer if it’s more comfortable to do so.
5. Shower or bathe on the day following the vasectomy and thereafter gently apply soap to the scrotum, rinse and blot dry avoiding rubbing. Using crushed ice in a ziploc bag or a bag of frozen peas held in place by jockey shorts over the supporter is a good way to prevent swelling. Alternating for half-hour periods off and on seems effective. Only non-aspirin pain relievers, acetaminophen preferably, should be used.
6. Neosporin or like antibiotic ointments (even plain Vaseline will work) can be used twice a day on the two wounds.
7. Use another means of birth control for 6-8 weeks post vasectomy, or until your sperm sample has been tested and shows no sperm. The sperm sample can be collected in a jar or container obtained from our office. If sperm is seen upon exam in the laboratory, protection will be necessary until a repeat test is done 6 weeks later. Some people retain sperm in their reproductive tract longer than others. This does not mean the procedure has not worked.
8. Refrain from sex for one week. Most patients prefer to have the procedure at a time when they can loaf a few days afterward. We advise you wait several days before heavy work or jumping.
9. It is important for you to ejaculate at least 12 to 20 times before your first semen test to clear out any remaining sperm in your tracts. Remember until the sperm test is negative for sperm, you can still get a woman pregnant.
10. A small amount of oozing of blood (enough to stain the dressing), some tenderness and mild swelling in the area of the incisions are not unusual and should subside by 72 hours. This should cause no alarm if there is no unusual amount of swelling of the scrotum or pain. If there is pain and swelling, or any substantial free bleeding, feel free to call the doctor at any time. If for any reason you cannot reach him or his partners please go to the closest emergency room.

11. If you have any questions about this information or other aspects of your procedure please don't hesitate to ask.
12. Most asked questions:
    - Q: Will this affect my sexual drive or ability?
      A: There is no indication that a vasectomy modifies the sexual drive in any physiological way.
    - Q: Will my semen look the same?
      A: Yes, most of the semen specimen is not made up of sperm and you can not tell the difference.
    - Q: Can the cords ever be put back together?
      A: This is possible, however, the success is variable and cannot be guaranteed in any one individual.
    - Q: Are there ever failures?
      A: Rarely. If there are more than one vas on each side, then this can be missed. This is a rare anatomical abnormality. Infrequently, a cord can reanastamose spontaneously (grow together without being attached surgically) and, again allow sperm in the semen.

- ❑ I have been told about the risks, benefits, and common problems with this surgery and of other methods of birth control. I have read and reviewed the state patient information booklet and consent, and I agree to be sterilized as I do not want more children.
- ❑ I understand that no birth control method is 100% effective and I need at least one semen test after the surgery to show there are no sperm in the semen.
- ❑ Until the semen test is negative for sperm, I understand I could still be fertile, have sperm, and could get my partner pregnant. I need the first test 6 to 8 weeks after the surgery after 12 to 20 ejaculations. If there are any sperm, I will need another test done and possibly need the surgery repeated. The best negative test is a single negative test at 12 weeks.
- ❑ I also understand even with no sperm found on the test rarely the vas deferens (tubes for sperm) can come back together even years later (1 in 1000 risk) and sperm could be released and pregnancy happen.
- ❑ I have also been told about the risks of the surgery including bleeding, infection, injury to other organs, vessels, or nerves, late complications like hematomas, granulomas, and method failure.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment and surgery with the following signature:

_____	_____
Date	Signature of Patient/Other Legally Responsible Person if Applicable
_____	_____
Witness	Interpreter

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